2 PERSONAL HEALTH CARE EXPENDITURES

In 1995, the Medicare program served an ever-enrolled population of 38.8 million beneficiaries.[1] These beneficiaries were eligible for Medicare for part or all of the year. Aged beneficiaries constituted 88.4 percent of this population, totaling 34.3 million; and disabled beneficiaries accounted for 11.6 percent, totaling 4.5 million. Beneficiaries who resided in communities for the entire year numbered 36 million; those who divided their time between a facility and the community numbered 745 thousand; and those who were in nursing home facilities for the entire year numbered 2.1 million. Of the 36.7 million part- or entire-year community residents, 11.2 percent were covered by Medicare fee-for-service-only; 10.1 percent were enrolled in Medicare health maintenance organizations (HMOs); 14.9 percent had Medicaid coverage; and the remaining 63.8 percent had supplemental private health insurance (PHI).

Personal health care expenditures (PHCE) by aged and disabled beneficiaries represent direct consumption of health care goods and services provided by hospitals, physicians, and other suppliers of medical care services and equipment.[2] The MCBS estimates of PHCE equal the sum of payments by Medicare, Medicaid, private insurance, households, and other sources. They include expenditures on Medicare-covered services as well as services not covered by Medicare, e.g., long-term nursing home care and prescription medicines. PHCE by Medicare beneficiaries constitute more than one-third of national health care spending, even though the Medicare population comprises only 14 percent of the U.S. population. Their patterns of spending and sources of financing are very different from those of the general population.

National Health Expenditures

The National Health Expenditures (NHE) report, produced annually by the Health Care Financing Administration's (HCFA) Office of the Actuary, presents estimates of national spending for health care and the sources funding the care since 1960.[3] It provides a valuable reference for policymakers at all levels to identify and follow trends in health care consumption. In 1995, $988.5 billion was spent on health care in the United States, an increase of 5.5 percent from 1994 in nominal dollars. Of the total NHE, $878.8 billion was used to purchase personal health goods and services. The remainder was spent on research, construction, program administration, net cost of PHI, and government public health activities. Per capita spending on personal health goods and services reached $2,330 for the non-Medicare population, up 3.2 percent from 1994 (Levit et al., 1996). Medicare beneficiaries are relatively high-cost users of personal health goods and services. In 1995, they spent $333 billion on personal health goods and services, accounting for 37.9 percent of national expenditures. Per capita spending by Medicare beneficiaries more than tripled that of the non-Medicare population, averaging $8,587 in 1995.

Certain segments of the Medicare population contribute significantly to total health care spending, because of their health care needs or socioeconomic status (Laschober and Olin, 1996). These segments include the oldest old (age 85 and over), the disabled, dual eligibles, and nursing home residents. Figure 2-1 presents per capita health care spending by these groups in 1995.[4] Not surprisingly, full-year nursing home residents had the highest per capita expenditures, followed by dual eligibles, the oldest old, and disabled beneficiaries. Racial and ethnic minorities had a mean expenditure comparable to that of all beneficiaries.

Trends in Personal Health Care Spending

The 1990s witnessed a pronounced slowdown in the growth of NHE, but Medicare beneficiaries' expenditures on health care diverged from the overall trend. Figure 2-2 presents data on personal health care spending by Medicare beneficiaries and the rest of the nation between 1992 and 1995. During this period, growth in national spending was the slowest in more than three decades (Levit et al., 1996). Compared to the 12 percent annual growth rates of the 1980s, nominal growth in national expenditures for per-

[1] See "The Sample" in Appendix A for a detailed explanation of the "ever-enrolled" beneficiary population.

[2] See Appendix B for a full explanation.

[3] National health expenditures include PHCE plus public program administration costs, the net cost of PHI, government public health activities, research by nonprofit groups and government entities, and the value of new construction put in place for hospitals and nursing homes.

[4] The categories of beneficiaries presented in this figure are not mutually exclusive.

sonal health care (PHC) slowed to 5-6 percent, and 3-4 percent if only PHC spending by the non-Medicare population is counted. Unlike the non-Medicare population, Medicare beneficiaries continued to average annual growth of 10-11 percent in PHC spending between 1992 and 1995. Nominal growth in health care spending for Medicare beneficiaries increased so much faster than spending by the non-Medicare population that the ratio of PHC spending for non-Medicare and Medicare beneficiaries shrank from 2 to 1 in 1992 to 1.6 to 1 in 1995 (Figure 2-2). After adjusting for population growth, annual growth in per capita spending on PHC averaged 8.5 percent for Medicare beneficiaries, or more than 3 times the average of 2.5 percent for the non-Medicare population (Figure 2-3).

Growth in total spending by Medicare beneficiaries mirrors growth patterns in the public sector of NHE. Public sector financing of health care is provided through programs such as Medicare, Medicaid, Department of Veterans Affairs, and state workers' compensation programs. Private sector spending, on the other hand, is mainly financed by consumers through out-of-pocket payments or PHI. For years, trends in health care spending by public and private sources have diverged. Public sector spending continued to grow at high rates in the 1990s (9.7 percent), whereas growth in private sector spending decelerated dramatically. Private sector spending grew 5.8 percent annually between 1989 to 1996, down from the 12 percent average annual growth seen during the years 1975-1989. Moreover, between 1993 and 1995, annual growth in private sector spending slowed to a mere 3.7 percent (Levit et al., 1996; 1998a; and 1998b; Smith et al., 1998).

Divergence in the growth of public and private sector spending on health care can be explained by myriad changes emerging in the health care marketplace in the 1990s. For instance, growth in managed care organizations, especially HMOs, and other cost containment measures initiated by the private sector contributed significantly to the slower growth in PHCE (Levit et al., 1996, 1998a, and 1998b). Nationally, managed care enrollment increased

Figure 2-1 Per Capita Personal Health Care Expenditures for Selected Groups of Medicare Beneficiaries, 1995

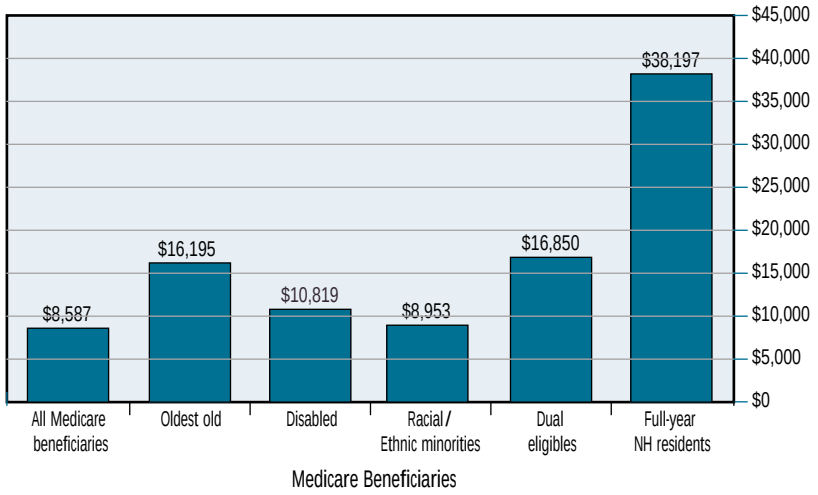
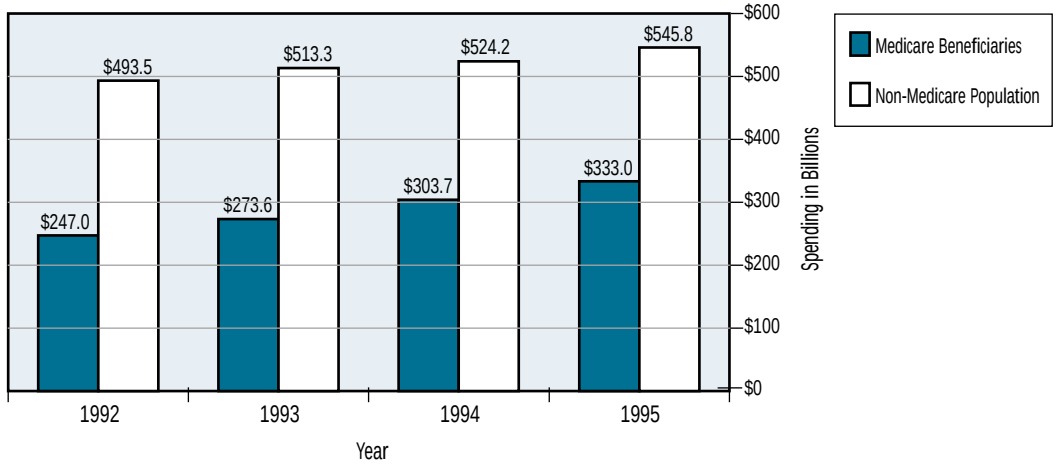
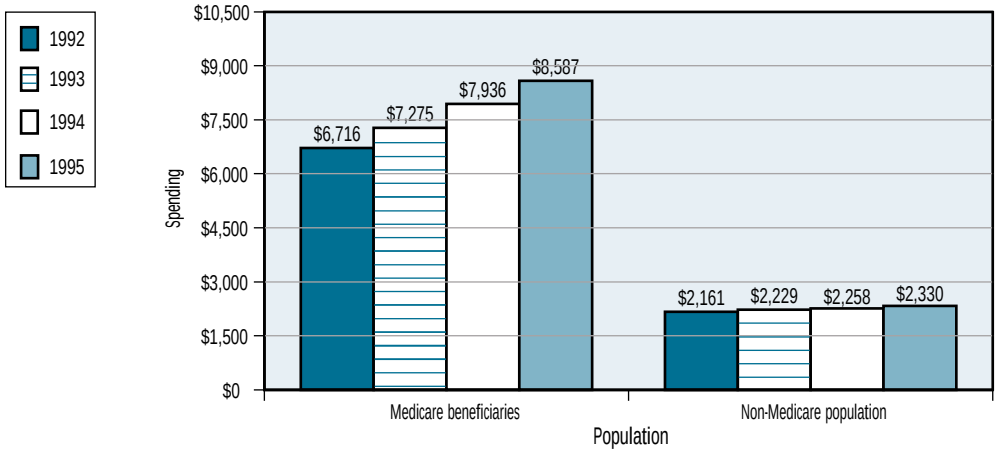


Figure 2-2 National Spending on Personal Health Care, 1992-1995



to 60 percent of the population in 1996, up from 36 percent in 1992 (Levit et al., 1998a). Although there is no consensus on the extent to which managed care contains cost, a growing body of research

Figure 2-3 Per Capita Spending on Personal Health Care, 1992-1995



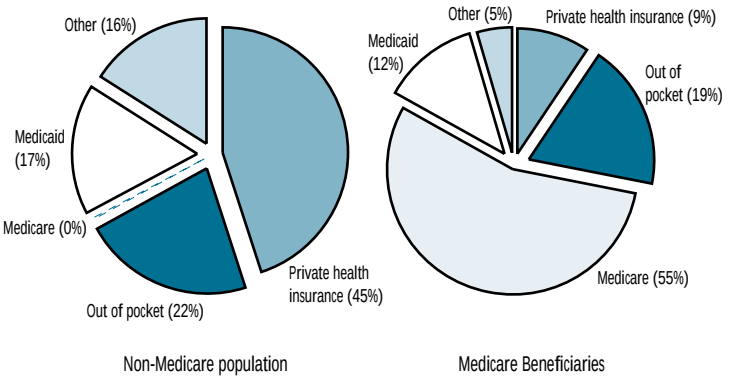
confirms that shifts in enrollment from fee-for-service coverage to managed care have restrained growth in PHCE (Miller, 1996; Levit et al., 1998a; Smith et al., 1998).

The effect of managed care on public sector spending, especially the Medicare program, may not duplicate that in the private sector, even though managed care enrollment among Medicare beneficiaries is projected to expand. Two reasons are that future growth in Medicare managed care could be limited because the best markets for Medicare managed care plans already have a large HMO presence; and it is uncertain whether HMOs can enroll and retain high-cost beneficiaries who seem to prefer Medicare fee-for-service (Olin and Lavis, 1998). Problems such as these may keep the growth in Medicare spending from falling to levels achieved in the private sector.

Funding Sources for NHE and Medicare Beneficiaries

Personal health care is funded by both private and public resources. Private resources include funds paid directly by consumers or their PHI, as well as other resources such as charity foundations.[5] Public resources consist mostly of payments by Federal, state, and local government through universal entitlement programs such as Medicare, or means-tested programs such as Medicaid. These sources of payment play very different roles in the financing of health care for non-Medicare and Medicare populations (Figure 2-4). In 1995, private funds consisting mostly of PHI and out-of-pocket payments accounted for 67 percent of PHCE by the non-Medicare population (Levit et al., 1996); whereas for Medicare beneficiaries, they financed 28 percent. This difference mainly stems from the role of PHI in financing health care for the two populations (45 percent for the non-Medicare and 9 percent for the Medicare population). PHI is not the primary payer for most health services consumed by Medicare beneficiaries, even though 67 percent of them have private insurance. The share of out-of-pocket payments by Medicare beneficiaries (19 percent) is more comparable with that of the non-Medicare population (22 percent). Nevertheless, average out-of-pocket payments by Medicare beneficiaries were 3 times as much, due to their much higher PHCE. Per capita out-of-pocket payments by Medicare beneficiaries were $1,605, compared with $514 for the non-Medicare population.

Figure 2-4 Distribution of Personal Health Care Expenditures, by Source of Funds, 1995



[5] To achieve comparability between the Medicare and non-Medicare population, "other private payments" in NHE were collapsed with "other public."

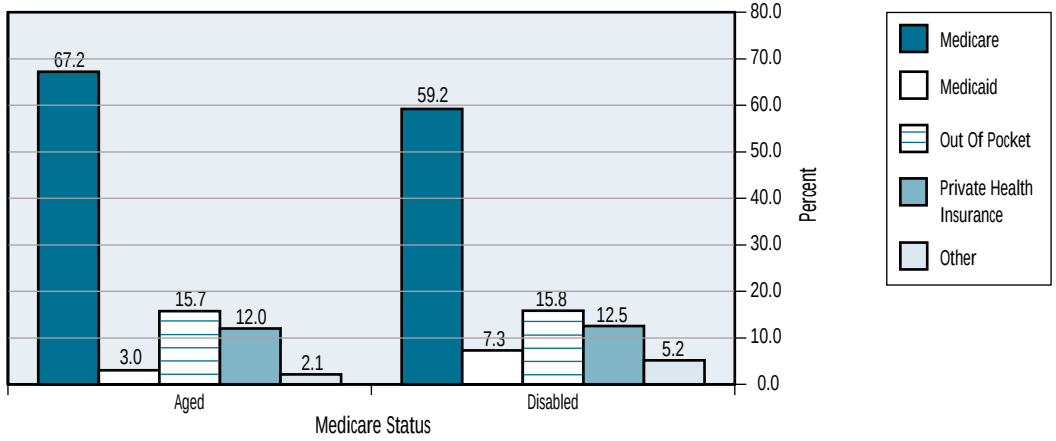
Public resources play a significantly more important role in health care financing for Medicare beneficiaries than they do for the non-Medicare population. Medicaid, the main public payer for health care for the non-Medicare population, financed 17 percent of their PHCE. On the other hand, public funds cover 67 percent of PHCE incurred by Medicare beneficiaries. Medicare, through the hospital insurance and supplementary medical insurance programs, was by far the largest payor (55 percent), with an average payment of $4,722 in 1995. Medicaid, acting as supplemental health insurance as well as the primary payer for noncovered services for eligible beneficiaries, paid another 12 percent of PHCE.

Because many nursing home residents depend on Medicaid for financing of their long-term care needs, the data in Figure 2-4 are not representative of some beneficiaries. Figure 2-5 presents sources of funding for aged and disabled Medicare beneficiaries residing in communities for part or all of 1995. Payment sources for aged and disabled beneficiaries do not show much difference from one another except for the shares paid by Medicare and Medicaid. The distributions of sources of funds for community residents again show marked differences from those for the non-Medicare population. Funding by private (28 percent) and public sources (67-70 percent) remained similar to those for the entire Medicare population. The share by PHI increased to about 12 percent, while the out-of-pocket share dropped slightly to 16 percent. Of the public funding, an even larger proportion of health spending by aged (67 percent) and disabled beneficiaries (59 percent) was paid by Medicare, while Medicaid played a relatively smaller role (3 percent for aged and 7 percent for disabled beneficiaries).

PHCE by Service Category

The distribution of personal health care expenditures by type of service has varied little since 1992 (Laschober and Olin, 1996; Olin and Liu, 1998). In 1995, inpatient hospital services captured the largest share in PHCE (30 percent), followed by long-term care (25

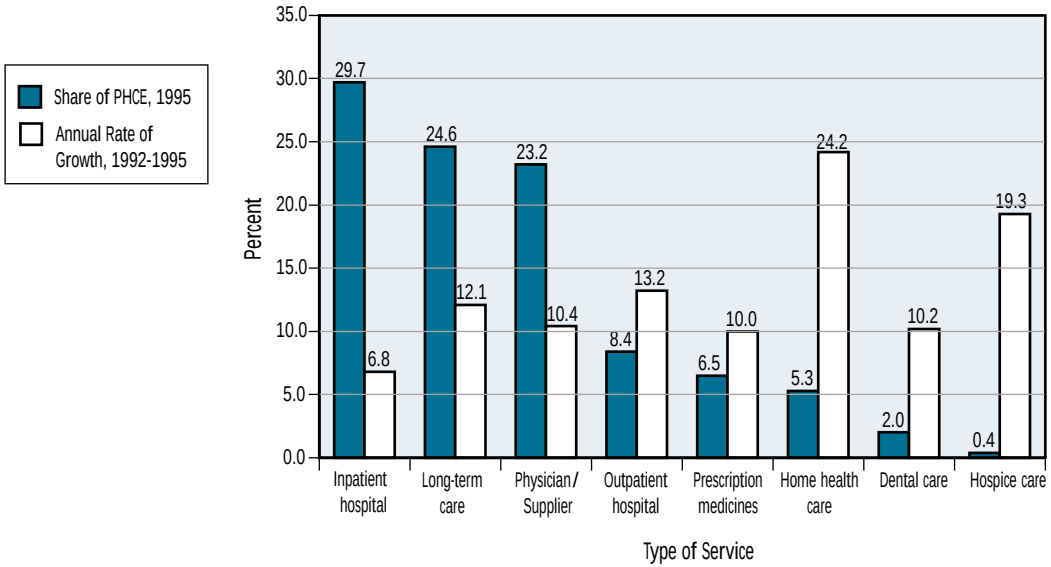
Figure 2-5 Distribution of Personal Health Care Expenditures for Community Residents, by Source of Funds, 1995



percent) (Figure 2-6). Ambulatory services, including physician/supplier services (23 percent) and outpatient hospital services (8 percent), remained at a little over 30 percent of PHCE for Medicare beneficiaries, in spite of gradual shifting from inpatient hospital services to physician services. Prescription medicines (7 percent) and home health care (5 percent) maintained about the same share of PHCE as in previous years.

Annual rates of growth vary considerably by type of service (Figure 2-6). Growth in expenditures on some services had a significant impact on PHCE either because of the magnitude of growth or because of the relatively large share of the service type in PHCE. Home health and nursing home care, with annual growth rates of 24.2 percent and 12.1 percent respectively, accounted for 40 percent of the growth in PHCE between 1992 and 1995. Ambulatory services, mainly outpatient hospital services and physician/supplier services, with annual growth rates of more than 10 percent, explained another 30 percent of growth in PHCE during the same period. Inpatient hospital services, with a lower than average annu-

Figure 2-6 Distribution of Personal Health Care Spending by Medicare Beneficiaries and Annual Growth Rate, by Type of Service



al growth rate (6.8 percent), accounted for 20 percent of the growth in PHCE. Hospice, dental, and prescription medicine, in spite of annual growth rates of 10 percent or more, had relatively minimal impact on growth in total health care spending because of their smaller shares in PHCE.

Summary

Per capita spending on health care by Medicare beneficiaries more than tripled that of the non-Medicare population in 1995. Medicare beneficiaries constituted 14 percent of the U.S. population, but they used 38 percent of national personal health care spending. Segments of the Medicare population that contributed significantly to the high cost include full-year nursing home residents, dual eligibles, the oldest old, and disabled beneficiaries. The distribution of PHCE by type of service has varied little since 1992, but this could change in the future if growth in spending continues to vary by type of service. Expenditures on home health care, nursing home care, ambulatory services, and inpatient services accounted for 90 percent of growth in beneficiaries' PHCE between 1992 and 1995.

The growth in PHCE by Medicare beneficiaries has diverged from that of the non-Medicare population. While the 1990s witnessed a pronounced slowdown in the growth of national spending on health care, Medicare beneficiaries continued to average annual growth of more than 10 percent in total spending, and 8.5 percent in per capita spending. These rates are 3 times as high as those for the non-Medicare population.

Spending by Medicare beneficiaries reflects growth patterns in the public sector of NHE. While public sector spending continued to grow at high rates in the 1990s, the growth in private sector spending decelerated dramatically. One of the main reasons for slower growth in the private sector has been the rise of managed care organizations, especially HMOs. However, Medicare managed care organizations have not had the same effect on public sector spending. They have a relatively small share of the Medicare market, and they tend to enroll and keep relatively healthy Medicare beneficiaries.

However, growth in real Medicare spending is projected to "level out in 1997-1998 and then to slow through 2000," primarily as a result of the Balanced Budget Act (BBA) (Smith et al., 1998). The BBA introduced major changes to Medicare's payment mechanisms, including prospective payments for a wide range of services, and cutbacks in payment formulas where rates were perceived to be overly generous to providers. These policy changes are expected to reduce Medicare payments and slow growth in Medicare spending. As a matter of fact, in the next 10 years, the slowdown projected for Medicare and Medicaid is considered to be the most important moderating influence for growth in health care costs (Smith et al., 1998).